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OPINION ARTICLE

Skin Cancer and the Dermatologist: Reflections on the Position Taken by the Spanish Society of Medical Oncology (SEOM)☆

El dermatólogo y el cáncer de piel. Consideraciones sobre el posicionamiento de la Sociedad Española de Oncología Médica (SEOM)

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A position statement on the role of the medical oncologist in the treatment of patients with cancer, published recently by the Spanish Society of Medical Oncology (SEOM), concludes with the following statement ''.. in light of the arguments presented above, the administration of systemic cancer treatments by specialists other than medical oncologists is not supported by sufficient rational evidence and could be detrimental to the well-being of cancer patients and the public health system''.[1]

As a group of dermatologists with many years of experience in dermatologic oncology, we consider this statement not only to be ill advised and opportunistic but also likely to generate needless uncertainty for patients with cancer, who for decades have been treated by a range of different specialists and specialist units.

It will, therefore, be necessary for SEOM to explain more fully in what way it could be deemed ''detrimental'' to patients and the National Health System that a specialist physician who works with cancer patients decides, exercising his or her authority as a doctor in a responsible and ethical manner, to treat a patient with an anticancer drug

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that is approved, available on the market, and included in the pharmacotherapy handbook of the hospital where the patient is being treated.

In our opinion, the statement can only be interpreted as a defensive strategy, devoid of any scientific basis, that can be easily refuted not just by dermatologists but by any group of specialists who treat patients with cancer. We stress the unfortunate nature of the message disseminated and the threat that this attitude poses to the multidisciplinary teamwork that is the cornerstone of care for patients with cancer—a multidisciplinary approach that is, moreover, generally accepted worldwide and specifically approved by our own health authorities as the standard of care for patients with cancer.[2] From this standpoint, the paragraph quoted, and other assertions in the position statement, require immediate clarification or amendment.

Returning to the specific issue of skin cancer, SEOM raises serious doubts in public about whether dermatologists, and all other specialists, have the necessary capacity, skills, and knowledge to treat a patient with skin cancer using a systemic medication. SEOM's statement totally disregards the fact that dermatologists and other specialists have been doing just that for decades, in Spain and in the most renowned hospitals in Europe, long before medical oncologists even considered skin cancers to be a potentially interesting type of tumor. Moreover, it is interesting to note that the start of SEOM's interest in such treatment coincided with the start of clinical trials in this field.

Until a few years ago, less than a decade, dermatologists in charge of melanoma units—which it is also curious to note are run by dermatologists—found it very difficult to get medical oncologists involved in the study and treatment of patients with melanoma. The current interest on the part of medical oncologists in basal cell carcinoma is likewise unprecedented, since this cancer was completely unknown to them until now. It is, therefore, difficult for us to see this self-proclamation by SEOM as the guardians of patients with cancer as anything but astonishing and opportunistic, when recent history demonstrates a very different story in the case of skin cancer. Until now, patients with cutaneous malignancies have been well cared for in Spain by dermatologists, who have taken on the role of coordinators of multidisciplinary teams made up of radiation oncologists, surgeons, nuclear medicine physicians, radiologists, pathologists, molecular biologists and, of course, medical oncologists. There is a reason why several teams of Spanish dermatologists are counted among the most outstanding international teams in this field.

Dermatology is an organ-specific, medical and surgical specialty concerned with the study of cutaneous diseases and their consequences, irrespective of the etiological or pathogenic mechanism or the ultimate treatment of the disease and, among such diseases, specifically, skin cancer and its consequences and the cutaneous manifestations of other types of cancer.[3]

Dermatologists understand the genetic and immunological basis of skin cancer and the natural history of these tumors and are familiar with the diagnostic techniques (dermoscopy, confocal microscopy, ultrasound) and the therapeutic options (immunotherapy, topical, immunomodulatory, surgical and regional treatments as well as intratumoral and systemic therapy) used in this setting. Consequently, they are well positioned and trained to provide patients who have skin cancer with a treatment and follow-up plan suited to their needs, which can include not only systemic treatment (a marginal tool in the case of skin cancer) but also a combination of the many other options currently available. Nevertheless, we do not claim, as SEOM has done, that we are the only specialists who can treat a person with skin cancer at all times.

Pharmaceutical or medical therapy is not the only treatment for cancer, an erroneous conclusion one might draw from the SEOM position statement. Patients with cancer and their friends and families go through a series of different situations, starting with diagnosis and initial treatment to continue on with follow up and in some cases local, locoregional, or distant progression. Each one of these situations calls for a specific care plan, which will involve the active participation of professionals from different fields, each one of whom has a specific role (physicians, surgeons, radiation oncologists, radiologists, nurses, family doctors, palliative care specialists, and psychologists). All of these professionals work together to achieve a cure when possible, to improve the patient's condition in many cases, and to provide palliative care when that is appropriate. They are there at all times, throughout this difficult journey, to accompany the patient and those close to them. By appointing themselves as the only possible commander on this journey and by undervaluing the role of all the other actors in this relentless battle against cancer, SEOM are not only distancing themselves from the multidisciplinary philosophy underpinning modern medical practice, the association is also involving cancer patients in a claim that would appear to have purely corporate aims.

Does SEOM imagine that in what we hope is a not too far distant future, when cancer can be treated from the outset with various kinds of drugs, that dermatologists will no longer be involved in the study, research, and care for people with skin cancer? We can cite a recent example from our own specialty. Fourteen years ago, we saw the start of a revolution in the treatment of psoriasis. Until that time, psoriasis had been treated mainly with topical medications, phototherapy, acitretin, methotrexate, and ciclosporin (a list that also serves to illustrate the dermatologist's very real experience in the use of immunosuppressive and immunomodulatory therapies associated with considerable toxicity). After the advent of tumor necrosis factor inhibitors in 2014, followed later by other biologic agents (interleukin [IL]12-23 and IL-17 inhibitors, etc.), dermatologists started to successfully use a group of drugs that provided obvious benefits to patients with psoriasis but which are associated with potential adverse effects that include tuberculosis, legionellosis, demyelinating disorders, and cytopenias, among others. If we apply the argument now advanced by SEOM, should we at that time have started to refer our patients to be treated exclusively by immunologists or internists?

In its statement, SEOM refers to the fact that the registered clinical trials of antineoplastic therapies were carried out in medical oncology units and clinics, advancing the argument that this makes them, as opposed to other specialists, the only physicians in a position to prescribe and use these drugs. This argument is not only just as weak as the others, it would also exclude the many medical oncology

units and clinics in the country that did not take part in clinical trials since, according to the argument, the medical oncologists in those units will not be qualified or trained to use these drugs when they become available.

The experience of dermatologists with biologic agents in the treatment of psoriasis (and with many other drugs, including rituximab in blistering diseases and bexarotene to treat lymphomas) provides evidence that these drugs can be used not only by the clinics involved in trialing them, but also by any physician interested in working with these treatments who acquires the skills necessary to use them safely and obtain good clinical results.

In its position statement, SEOM stresses the role of clinical trials as a training vehicle, in the knowledge that pharmaceutical companies in the sector have adopted a common position that clearly limits professional and scientific development in other areas of knowledge. This attitude only serves to further discredit the argument that ''access to clinical trials with new anticancer drugs (which are largely carried out in medical oncology departments) is the right of oncology patients''.[1] SEOM has, once again, made a mistake in advancing this argument. The real and legitimate right of people with cancer is that we, as doctors, should observe at all times the four basic principles of health care ethics that should govern all our actions: autonomy, beneficence, non-maleficence, and justice. In any clinical situation, the therapeutic option that fulfils our duty to observe these principles should be the first one considered, whether or not it is experimental. And that is the task of multidisciplinary committees: to analyze each case from this bioethical perspective and identify the most appropriate therapeutic plan in the best interests of the cancer patient, without any reference to personal agendas or other interests.

The SEOM position paper also emphasizes that ''The administration of anticancer treatments of any type by a clinician with insufficient knowledge about the pharmacology of these drugs can put patients at unnecessary risk posed by a failure to adjust the dose appropriately or poor management of adverse effects''.[1] Dermatologists—like all specialist physicians—are doctors, and it cannot be argued that because they are not medical oncologists that they are not qualified to make therapeutic decisions or not responsible for the decisions they make. The necessary competence in this case is not the exclusive purview of a particular specialty (such as medical oncology) but is rather the responsibility and obligation imposed on all physicians by the duty and standard of care that must govern all their decisions, even without reference to other fundamental issues, such as the right of physicians to prescribe as they see fit, clearly recognized by Spanish law. Perhaps SEOM should ask the medical oncology units and departments about the protocols they use to manage the toxicity of these drugs, because they might be surprised to learn that in most patients toxicities are managed in consultation with specialists from other departments (including dermatologists because of the dermatological adverse effects associated with the use of these drugs).

In another statement, which is no less inopportune, biased and confusing for people with cancer, the paper affirms that ''.. We believe that cancer patients have the right to demand that their disease always be assessed and their condition managed in most cases by a medical oncologist, although decisions will obviously be taken in the context of a multidisciplinary approach in cancer committees, given that other specialists must also participate in the management of the disease''.[1] Although it is obvious that this paragraph does not affect the care that dermatologists provide for patients with skin cancer, it can serve as a starting point for a review of some general concepts about care for patients with skin cancer.

Surgical intervention is still the first treatment option considered in a patient with any type of skin cancer, including melanoma. In the case of primary tumors, and recurring tumors that are considered operable, surgery is the first option, and it has been shown to offer the possibility of a complete cure. This is why the exclusivity demanded by medical oncologists is unreasonable, unrealistic and impossible, given the limited knowledge of those specialists about basic surgical practice due to the nature of their specialty and the body of knowledge they acquire during their training. Moreover, visceral metastases occur in only 20% of patients with melanoma. In other words, the clinical situation of 80% of patients with melanoma (stage I, II, III and even M1a) will be one for which the dermato-oncologist is not only qualified, but in fact has available in numerous dermatology units the necessary technology to offer a complete therapeutic plan, including medical and surgical options developed and agreed in the context of a multidisciplinary melanoma committee. In the case of basal cell carcinoma, surgical excision of the tumor achieves a satisfactory outcome in 95% of all cases, and metastatic progression is the exception. Even the most advanced cases have been treated, after complex surgical interventions, with the help of a radiation oncologist. The complexity of surgical interventions and radiotherapy (the treatments used until now to treat advanced basal cell carcinoma) and the complications associated with such treatment far exceed the complexity associated with the use, for example, of vismodegib.

SEOM emphasizes the fact that the medical oncologist is the ''specialist with the greatest knowledge and training about all the possible treatment options for cancer (oral and not oral)''[1] in an argument clearly based on self interest in that it makes direct reference to the new intratumoral therapies. Since when have medical oncologists been interested in intratumoral treatment with bleomycin, methotrexate, or 5-fluorouracil for nonmelanoma skin cancer in fragile patients who are not candidates for surgery? Or in intratumoral treatment with IL-2 in patients with melanoma and cutaneous metastases? Or in topical immunomodulatory treatment for epithelial cancer?

Other, more roundabout, arguments are advanced relating to the structural or organizational aspects of hospital care, making reference to the necessary presence of on-call oncologists or to the existence of oncological day hospitals. Once again, SEOM should be more aware of the great variability between different hospitals and medical oncology departments in Spain. Once again, this argument represents a clear limiting factor for medical oncology departments and units that do not have an on-call oncologist or a dedicated day hospital, as is the case in the hospitals where some of the authors of the position paper work, departments where, according to their own argument, cancer treatments should not be administered.

In conclusion, we reject SEOM's position because it represents a threat to the generally accepted standard of care for people with cancer, which calls for a multidisciplinary, collaborative, integrating, caring and transparent team working towards a common goal: to make available to our patients all the professional, technological, and therapeutic resources that can offer them the possibility of a cure or enhance their well-being. In this setting, the medical oncologist is, like all the other specialists involved, a necessary member of the team, although without the unjustified and self-appointed exclusive role which SEOM has attempted to appropriate.

It would probably have been more constructive to underscore the value of the care provided by medical oncologists to patients with metastatic disease in conjunction with that of the professionals working in palliative care units and radiation oncology departments. In our opinion it would have been of great interest to consider the definition of roles, and in which clinical scenarios the contribution of each type of professional is needed. Consequently, we cannot be party to this attempt by SEOM to take over all the roles involved in the care of patients with cancer. Reducing the complex care of patients with cancer to a debate on an exclusive right to prescribe a particular medication can only be described as an extreme simplification of a public health problem on which it is essential that we continue to make progress. Given SEOM's position of responsibility in this field, it should not be the association generating controversies that can only weaken us all in our pursuit of our goal and strengthen our common enemy: cancer.

Conflicts of Interest

None.

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